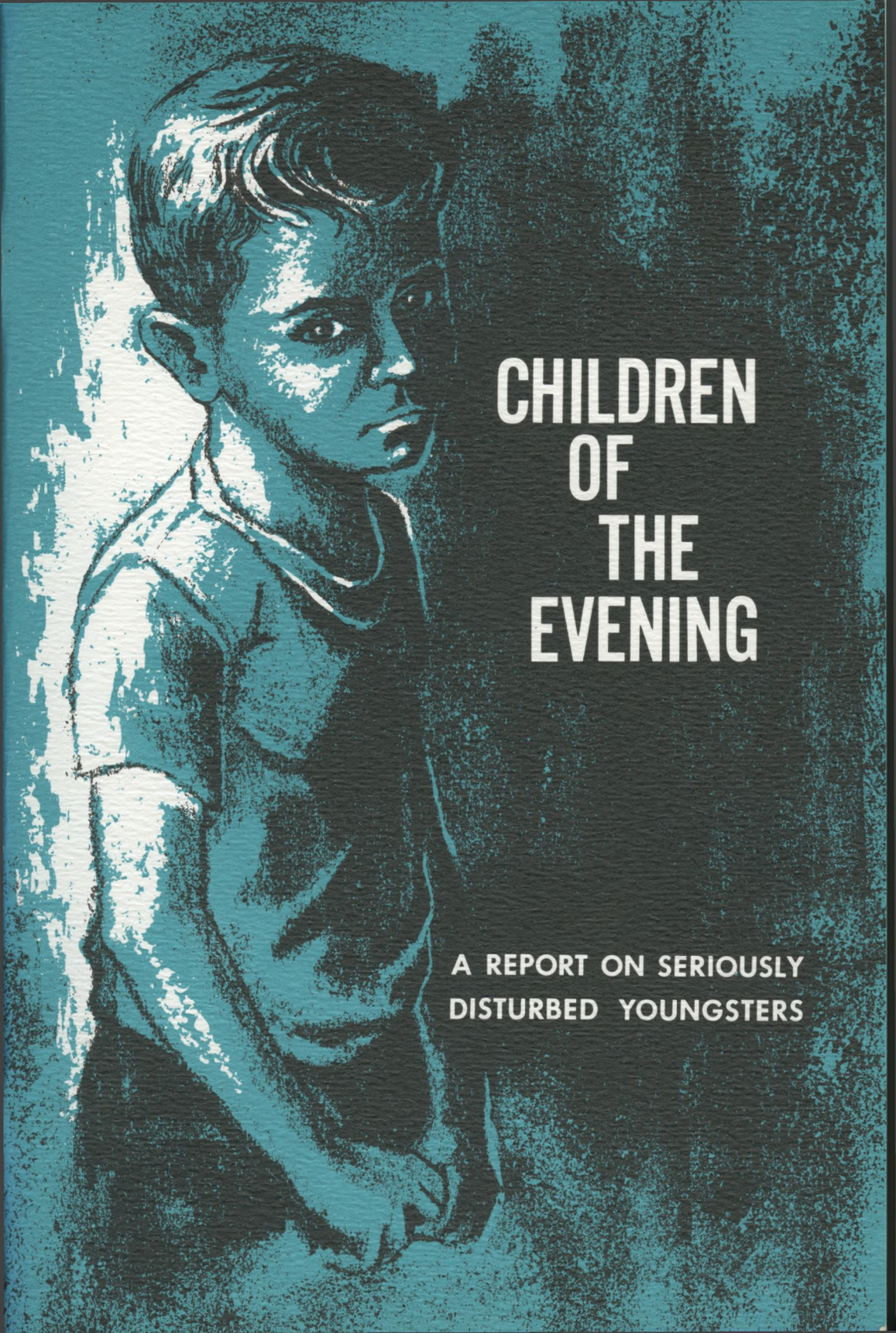

CHILDREN OF THE EVENING

A REPORT ON SERIOUSLY DISTURBED YOUNGSTERS

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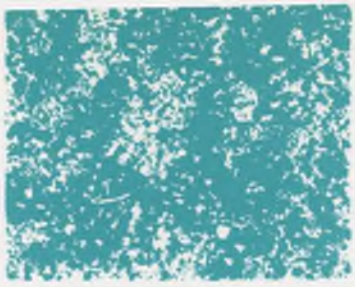
CHILDREN OF THE EVENING

BERT KRUGER SMITH



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INTRODUCTION

When a health or social problem needs attention, what group serves as a spur to action? Is it the experts who know the etiology of the problem? Sometimes it is. More typically though, the lead is taken by citizens who have known the need in some first-hand way. For example, Clifford Beers, who wrote with conviction about his own experiences in a mental hospital, enlisted the help of friends to establish the National Committee for Mental Hygiene.

Our culture is biased in favor of meeting the needs of children, but neither professionals nor community leaders have moved far in helping with problems of the mentally ill child. Relatively few services and facilities exist. This fact was faced in one section of the country when 12 Junior Leagues banned together in an area study, which encouraged the professionals to outline the extent of the problem and to spell out what might be done. Results showed that some measures for improvement are near at hand and non-costly, while others require buildings, teams of workers, and high budgets.

In its publications policy, the Hogg Foundation attempts to make recent findings available in printed form or to outline the dimensions of a problem for groups interested in action. In keeping with this idea, the Foundation, through Bert Kruger Smith, its editor, has summarized the views and data provided by professional workers in the field and has outlined some possible steps which might be undertaken in communities of any size. *Children of the Evening* describes the scope of the problem in terms which should interest citizens and professional workers.

Robert L. Sutherland
The Hogg Foundation for Mental Health

ACKNOWLEDGMENTS

EVERY CREATIVE PRODUCT owes its existence to dozens of people, many of whom cannot be acknowledged. There are authors of articles which have been read but not noted specifically, friends and family members who have discussed and helped to clarify ideas, acquaintances who have made suggestions about how a pamphlet might be improved.

Unfortunately, to acknowledge help is both a positive and negative act, for at the same time that one gives appreciation, he may fail to name someone to whom thanks are due. Therefore, to all of the persons who are unnamed but whose help has been invaluable, this is a special statement of appreciation.

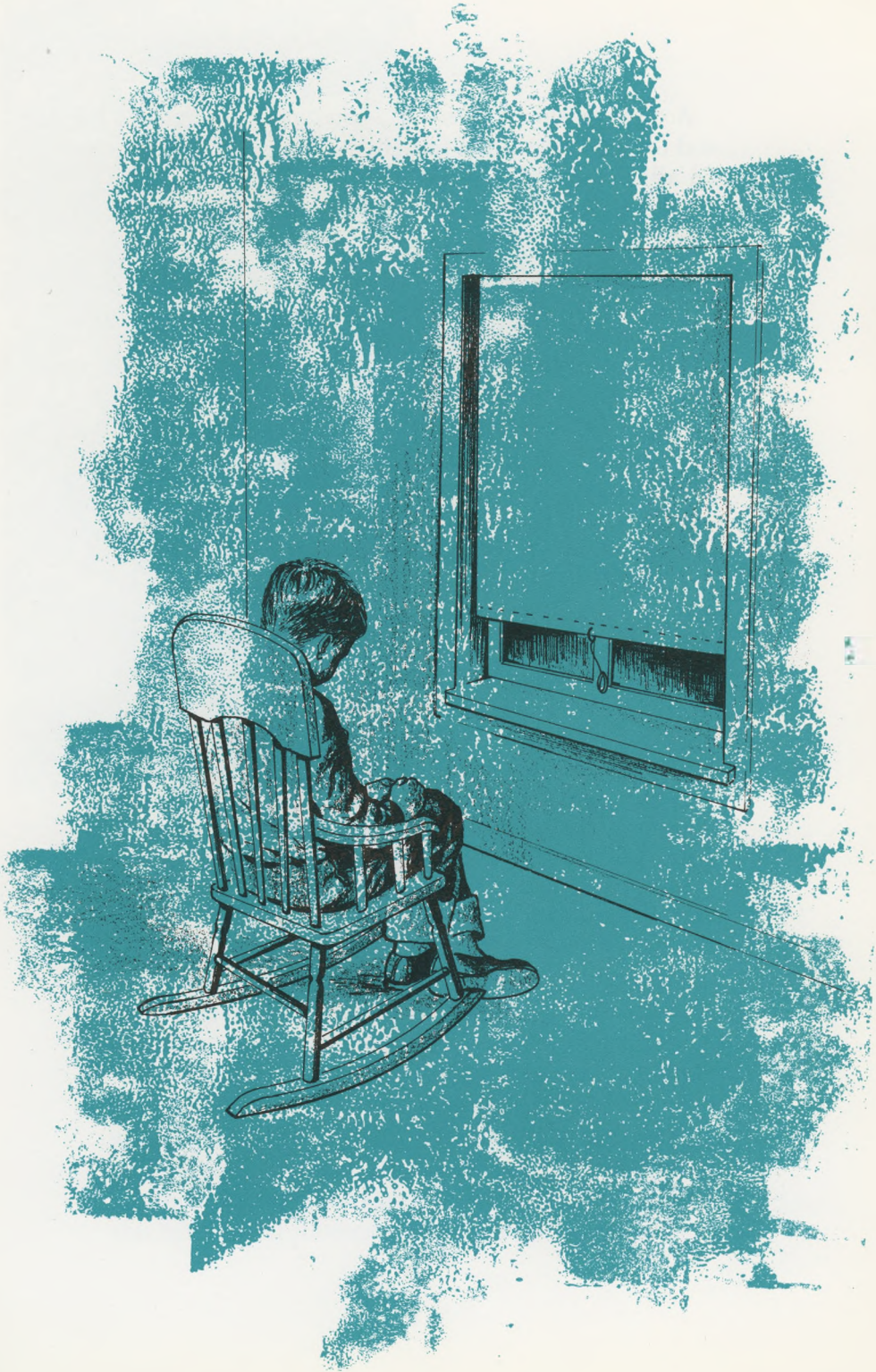
A distinguished battery of experts gave their time and their advice to the formation of this publication. To all of them the author is extremely grateful. Dr. Robert L. Stubblefield, Dr. Harry N. Little, Dr. Nicholas Hobbs, Dr. Irvin A. Kraft, Dr. Grace Jameson, and Dr. Eugene C. McDanald Jr. all helped to bring the manuscript to completion.

Members of the Junior League Public Affairs Committee, under the chairmanship of Mrs. Herbert Denton of Galveston, read the material and made many excellent suggestions. They even enlisted the help of their friends and husbands, some of whom were psychiatrists.

Members of the Hogg Foundation staff—Dr. Robert L. Sutherland, Dr. Wayne H. Holtzman, and Dr. Bernice M. Moore—gave much of their time in helping to plan the presentation and in suggesting ways to improve this paper. Other Hogg Foundation advisors, Dr. William C. Adamson, Dr. Joseph M. Bobbitt, and Dr. Ralph W. Tyler, gave thought and time to making suggestions for compiling this material in its best fashion. Mrs. Dorothe Bozza compiled the bibliography.

If the publication has fulfilled its purpose of informing people about the severely disturbed youngster and about possible ways of helping him, much of the credit goes to this highly dedicated group of people.

BERT KRUGER SMITH



DAYTIME BELONGS to normal children. It is a world to be shaped like bright clay between their eager hands. Daytime is a symbol of beginning and brightness, of warmth and living. The sounds of daytime children, too, are mostly delighted giggles, excited shouts, or earnest, exploratory talk.

Symbolically, there are evening children—disturbed youngsters who have turned away from the brightness of youth and who have entered a gray, shaded area of life. For them, the nightmare of prolonged mental illness may be close by. Even the sounds they make are different—the almost no-noise of a sigh rising from a chest too small to contain the weight of worry, the rustle of paper being torn, or the scurrying of feet when a little one attempts, in a frenzy of nonunderstanding, to find the daytime path.

It is evening in Middleton, a city like a giant hand mashed into the prairie, its misshapen fingers jutting out in three directions. It is evening, the moment when the glove of night has not yet covered the hand of day. A waiting time.

For the Fergusion family in the white brick house in the suburbs it has hardly been daytime for the three years since Cindy was a year old. That is when they discovered that this still youngster is what the doctors call "mentally ill," "schizophrenic," "autistic," or other equally technical names for a tiny brown-haired child for whom the word "Cindy" is too long to say. Helen Ferguson stands in the doorway of her daughter's room and watches her little girl, who sits, completely alone in her rocking chair, a silhouette in the darkening room. There is no need to call out to Cindy, for the invisible wall between them is higher than the room and wider than the house. Helen turns away . . .

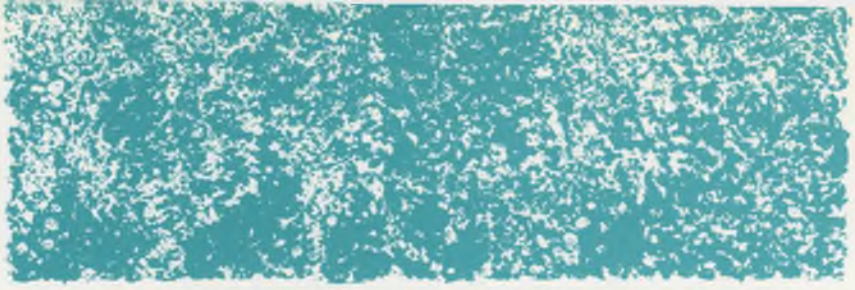
In the house with the gray shingles on the other side of town, the Millers are seated around the dining room table, but no one is eating much. Milton, who has been sent to his room, is yelling steadily. The Millers are not sure what to do next. They do not know that Milton is an emotionally disturbed or possibly a brain-damaged child or both. They simply are aware that he is a problem everywhere he is, that he is in danger of being expelled from school and that his constant restless activity is almost more than they can bear.

Miss Henderson, Milton's teacher at Willow Brooks School, sips her coffee and reflects on the day and on Milt Miller's behavior. She recalls his reports from other schools in other towns. "Restless," "terribly nervous child," "trouble maker." And she begins to realize with a special insight that Milt has a short attention span and is not being willfully disobedient.

Suddenly Miss Henderson is aware of what she must do. First thing tomorrow she will talk with the visiting teacher, whom she had not consulted before about Milton. They will plan together; and if it seems indicated, they may refer Milt to the child guidance clinic. Miss Henderson smiles, grateful for the facilities Middleton has for a boy like Milton.

Children like Milton and Cindy, who shall be considered in this pamphlet, are severely disturbed and should not be confused with mildly disturbed or with normal children! There is no child who has not at times withdrawn from contact with the family, who has not yelled long and angrily, or who has not acted in other anti-social ways. We are concerned in this pamphlet with the child whose personality and behavior disturbances are grave and constant—so much so that the youngster may be alienated from the everyday world—or his family or school may be unable to cope with him because of his disturbed behavior.

It is hoped that parents will not attempt to apply to their own children the symptoms of the seriously disturbed described here, for it is the constancy and the magniture of personality disorganization and of the disrupting behavior which characterize the very disturbed child.



Who Are The Seriously Emotionally Disturbed Children?

How many Cindys and Miltons are there? Who are they? Where are they? What is being done for them? These are the questions which spring to mind as we talk of severely disturbed children.

Estimates vary as to the number of mentally ill children and young people in this country. It is estimated that about .6 percent are psychotic and that another 2 to 3 percent are severely disturbed. It is further estimated that an additional 8 to 10 percent of our young people are afflicted with emotional problems (neuroses and the like) and are in need of specialized services. However, only about 5 to 77 percent of the children who need professional mental health care are getting it. According to best available figures, only about 500,000 children are currently being served by mental health facilities—clinics, hospitals, private therapists. However, more than 10,000,000 young people under age twenty-five need knowledgeable help.[1] Among disadvantaged preschoolers, observation indicates that about one-third may suffer from emotional or mental disabilities.[2]

These children have been variously described by psychiatrists, psychologists, social workers, writers, but perhaps never more vividly than by Mira Rothenberg, the therapist who wrote:

> I believe that children like Jonny, whether we call them schizophrenic, autistic, or seriously disturbed emotionally, are not very different from other children. They need, they want, they hurt, they fear, they love, they hate and die just like all of us. The difference is a matter of degree, of how they defend themselves against their terrors and their wants. We withdraw a little when we are hurt and cry a bit. They withdraw all the way and build a shell around themselves so that the awful hurt can never happen again. They are just one big tearless sob, living inside the shell,

[1] *Crisis in Child Mental Health: Challenge for the 1970's* (New York: Harper & Row, 1969, 1970), pp. 253–254.

[2] *Ibid.*, p. 257.

hardly partaking of life around them.
And since they are so little and the hurt happened so early, the burden is too great for the strength within them, nor is there enough understanding in the world to help them venture out.
All work with such children must be based on an understanding deep enough to see beyond their defenses, the self that they are hiding. Then they can begin to trust and hopefully to come out on this new bridge of trust from their private world to reality.[3]

This very morning thousands of children woke from fretful, frightened sleep without hope, without joy, without peace, looking upon a day as drab and shadowed as evening. They may have arisen and spent the night in restless wandering about the house or sitting for hours in a chair, alone and quiet, in a dark room.

Some of them, living in homes of comfort, are terrified of starving; others are so afraid of poisoning that they will starve themselves. Some have wild delusions of grandeur to compensate for their feelings of utter despair. Some have fears of persecution, as real to them as if they were in a Nazi prison camp suffering all the tortures of that nightmare.

A few of them are frightened of change. Everything around them must be in the same place at the same time. Any movement of furniture or disruption of routine appears threatening to them.

There are boys and girls so compulsive about cleanliness that they will not eat food which has been touched by anyone else or handle a book which someone else has held. Others go through ritualistic motions of cleaning each part of their bodies. There are children who are compulsive eaters, others who vomit everything they swallow, and some who refuse food altogether. Some children hide their bodies from everyone's eyes, others masturbate openly. There are others whose body functions an uncontrolled.

Some of the older children withdraw even in their speech and talk in a strange mixture of words or else translate their feelings into a kind of poetic metaphor.[4]

[3] Mira Rothenberg, "The Rebirth of Jonny," *Harper's Magazine*, CCXX (February, 1960), p. 66.

[4] Bert Kruger Smith, *No Language But a Cry* (Boston: Beacon Press, 1964), pp. 7–8.

A teacher expresses her view of the disturbed child:

> There are great differences among the children. It is difficult to discover even superficial resemblances among them—very difficult because there are very few. There are the hyperactive children and there are the phlegmatic ones who are licked before they start. There are the verbal ones who can talk a wonderful line but who can't put a plate in front of each of three chairs successfully. . . . There are the ones who attack an activity, can stay with it for about a minute, and then are exhausted and fall apart. There are the others who can't start an activity until you warm them into it, get them rolling—and this may take ten or fifeen minutes—and then they're in business. . . .
>
> We must be willing . . . to search for and recognize the child's mechanisms for avoiding failure, mechanisms for covering up an anticipated inadequacy, mechanisms for avoiding anxiety. . . .

We must be ready to go as far back in the development of the child as is necessary. We must maintain the attitude that nothing is too elementary, nothing is too small, no gap in the development is too tiny to fill in.[5]

Thus we see that the seriously disturbed child may wear a dozen different faces, like the various distorted reflections in carnival mirrors, but behind the distortions there is a child who is afraid to trust, a child who lives behind a wall of fear, who defends himself by remaining behind that wall. He may show his problems by multiple developmental symptoms like thumbsucking, soiling, or masturbation; he may demonstrate catastrophic anxiety; or he may reveal severe difficulties in relationships with parents and peers. Chameleon-like, he may resemble in some ways a dozen other kinds of children suffering from other disorders, but always behind his hyperactivity, his withdrawal, or his excessive compliance is his unspoken call for help to some adult who can tear down the wall of fear.

The mentally ill child, the emotionally disturbed child, or the brain-damaged child—all of these terms appear in the literature—may be misdiagnosed for a period of years because many of these

[5] Elizabeth S. Freidus, "A Teacher's View," *The Child with Brain Damage*. Proceedings of the 1959 Annual Meeting of the Association for the Aid of Crippled Children, pp. 19–21.

conditions may mask themselves in the guise of retardation or deafness, speech defects, or motor disorders.

The Joint Commission on the Mental Health of Children has formulated the following definition of emotionally disturbed children: An emotionally disturbed child is one whose progressive personality development is interfered with or arrested by a variety of factors so that he shows impairment in the capacity expected of him for his age and endowment: (1) for reasonably accurate perception of the world around him; (2) for impulse control; (3) for satisfying and satisfactory relations with others; (4) for learning; or (5) any combination of these.[6]

The seriously disturbed child is often not retarded, though he may function as though he were a retarded youngster, or a retarded child may be so frustrated by his handicap that he develops emotional problems.

Degrees of Disturbances

Just as in many purely physical diseases, there are many degrees of emotional disturbance. Some youngsters with minor disturbances are able, with the loving and understanding care of their families and therapists, to come from behind their wall of fear. Many children can be helped by visiting teachers in the schools. Others may be treated successfully on an out-patient basis in child guidance centers. Still others are unable to function except after prolonged and intensive residential treatment or long-term placement in a mental hospital, and some, tragically, cannot be helped by the means we now know.

What Causes These Disturbances?

In both adult and childhood mental illness, research goes on continuously to find the causes of disturbances and to search for cures. Many people would blame environment for all the ills of

[6] *Crisis Child Mental Health*, p. 253.

these youngsters, and there are others who put the entire responsibility on heredity. Both schools of thought are partly right and partly wrong.

> At present, causation of these disabilities is incompletely known and understood. There is general agreement among behavioral scientists and other mental health professionals that the causation of these problems is various and multiple and is related to the interaction of constitutional and biological factors; life experiences in growing up, especially in the family; and social and economic stresses and/or deficits in the larger environment. In the past decade, a shift in thinking has occurred within the mental health professions. There is less focus on psychological conflicts within the individual and increasing concentration on the social, familial, and cultural factors. Further, psychoanalytic theories over the past thirty years have placed increasing emphasis on developmental phases and crucial growth processes during infancy and childhood.[7]

While many people who read about emotionally disturbed children feel that they know some of the basic causes of the ailment, those who work in the field are more often baffled than certain about causes of the illness. In the book, *Emotional Problems of Early Childhood*, three French doctors discuss the case of Daniel, whose early years were uneventful and easy and who began a serious regression at the age of two and a half. Although two events, the birth of a baby sister and the death of a person close to the mother, occurred at about that time, the authors do not feel that either event was in itself serious enough to cause the damaging illness in the child. In fact, they say:

> These considerations, however, do not provide us with a satisfactory answer to our questions of etiology, and we are tempted to hypothesize hereditary constitutional factors as an easy way of filling the void. . . . In fact, we must conclude that this case presents us with important questions that we are at present not able to solve, and underlines the vast area still to be explored in regard to problems of ego development and pathology as manifested in the psychoses of childhood.[8]

[7] *Crisis Child Mental Health*, p. 259.

[8] George Heuyer, M.D., Serge Lebovici, and Yves Roumajon, "A Case of Psychosis of Affective Etiology in a Young Child," *Emotional Problems of Early Childhood* (New York: Basic Books, Inc., 1955), pp. 363, 377.

For a long time parents of mentally ill children carried with them the added burden of guilt to the sorrow they already felt at the illness of their youngster. Often it was assumed that they were damaging their children in some unknown manner. As more and more attempts are made to solve the mystery of schizophrenia, chemical factors seem to show up as possible clues to trouble in some cases. It is true that relationships between parents and child often have to be reshaped if the child is to improve, but it is not true that parents are always thought of as the primary cause of the serious disturbance. Rather, the trend toward consideration of biological factors in mental illness has released some parents from their self-depreciation and self-punishment and left them free to work for the child's growth. The organic approach takes two forms: the first is that the hyperactivity or passivity displayed by the ill child springs from interference with the normal development of the central nervous system; the second is that there may be a biochemical basis for the difficulty which drugs can help to overcome.[9]

Other factors which are suspected of causing childhood emotional ills are birth experiences and physical illnesses. Even hereditary factors are being re-examined, although only rarely is there more than one schizophrenic child in a family, except in the case of identical twins.

Dr. Maurice Laufer sums it up this way in discussing the place of brain damage as a cause of emotional disturbances of children:

> But we must be clear—there are many other possible causes (than brain damage) for emotional disturbance with children. Some may have existed for a given child with this condition regardless of its presence, and many operate in him as in other children. It is also possible that the existence of this condition renders him more readily susceptible to the noxious effect of such purely psychological factors as emotional disturbances. Finally, it is possible that his emotional disturbance is secondary to the interpersonal and intrapersonal difficulties caused by the central nervous system dysfunction. Or there may be any combination of these. In other words, it isn't clear and simple.[10]

[9] Steven B. Getz and Elizabeth Lodge Rees, *The Mentally Ill Child* (Springfield, Illinois: Charles C. Thomas, 1957), pp. 23, 24.

[10] Maurice W. Laufer, "A Psychiatrist's View," *The Child With Brain Damage*, p. 14.

Although many of these illnesses come from organic causes, some can be traced directly to many kinds of separation from parents or family, as in the case of Paul, an abandoned child, who was described by his two Parisian doctors. Paul had been separated from his mother when he was two months old and by the time he was 18 months old had been moved 14 times. He seemed deaf and substantially retarded. Paul was kept in the hospital much of the time when he was undergoing therapy and was given special attention by several nurses and the therapist.[11]

In summarizing his case, the doctors conclude:

The child's general defense is a passive refusal of contact (not moving closer, not looking, not hearing) *as a denial of the possibilities of contact.* . . .

> In short, Paul defended himself by passively denying the possibilities of interpersonal relations against the numerous separation traumas which he had undergone. He exhibited total denial of auditory interchanges, partial denial of visual interchanges, and limitation of physical contact. In all respects, objects outranked persons. . . .
>
> In cases like Paul's which appear to be reactions of arrested development because of absence of an adequate mother figure from birth, the treatment of building up a relationship which acts as a bridge between the child and the world of people, followed by the provision of a mother person, is all that is required.[12]

Thus we see that Paul, whose gift of self was rejected time after time by those who took care of him, finally closed the wound of rejection by building up a thick scar tissue of isolation.

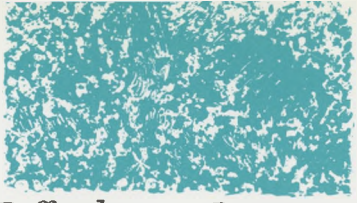
Here, you may say, lies the cause for the behavior of all emotionally ill children!

Like so many pat descriptions, this one is true in only a small percentage of the cases. Take Jonny, for example. He spent his first three and a half months in an incubator; and while he had warm and loving parents, ". . . Jonny existed but did not live, tenaciously holding on to life, yet not taking part in it beyond the minimum needed for survival."[13]

[11] Marie-Cecile Gelinier-Ortigues and Jenny Aubry, "Maternal Deprivation, Psychogenic Deafness and Pseudo-Retardation," *Emotional Problems Childhood*, pp. 231–247.

[12] *Ibid.*, pp. 241, 242, 247.

[13] Rothenberg, "Rebirth Jonny," p. 62.



Difficulties in Diagnosis

One of the most difficult tasks in helping these youngsters comes in diagnosing their problems early. Over and over the literature discusses why the problem is so acute. If the onset of the mental illness comes very early in the life of the child, the parents—and the pediatrician—may not be able for some time to differentiate between this illness and retardation. Again, if the youngster is a first-born, the inexperience of the parents in their expectations for the child may keep them from recognizing abnormal behavior.

Because mental illness in children is still a relatively unrecognized phenomenon, child psychiatrists often do not get to see and treat psychotic children until their illness has "set" after a year or more. For many years mentally ill children whose progress was halted or who were regressed were classified as retarded and placed in institutions for the retarded. Many children in such institutions today undoubtedly suffer primarily from mental illness.

Perhaps one of the most imperative needs of our day, according to the experts, lies in early diagnosis of these children. As Dr. Marian C. Putnam says:

> It is imperative that doctors, nurses, and other child care workers become acquainted with the early diagnostic signs and treatment possibilities for atypical children, since a "wait and see" attitude, which has generally seemed reasonable and safe for the irreversible types of mental retardation, is highly inappropriate here. Unfortunately, it is just the earliest manifestations of childhood psychosis that are the most difficult to delineate in clear-cut terms.[14]

Where the difficulty manifests itself dramatically, as in the sudden withdrawal of a normally active child from the family, the persistent refusal of food, or acute anxiety or panic states, parents and therapists are more likely to take immediate action on the child's behalf than when the onset has been insidious and evasive.

Because diagnosis of such conditions is being made with greater accuracy than formerly, it is hard to pinpoint statistics and to say that there are more cases of childhood psychosis than formerly or to reinterpret the statistics as being indicative of better diagnosis than before.

[14] Marian C. Putnam, "Some Observations on Psychosis in Early Childhood," *Emotional Problems Childhood*, p. 519.

Where Are These Children?

Everywhere! They come from many kinds of home environments.[15] Some of them are only children, some the oldest, and some the youngest in the family. Troubled boys outnumber girls more than four to one under the age of twelve. Some of these children are in school, meeting failure—causing problems, retreating farther within their own walls.

> The scarcity of psychiatrists and the staggering cost of long, drawn out psychiatric treatment have produced exactly the picture one could expect. If troubled children can somehow limp along, scraping through school and through life, their problems are apt to be ignored. . . . Some of their childhood problems may eventually flower into adult full-fledged mental illness. In many instances, if the problem is very deep, a child is simply tagged feeble-minded or slow, and no attempt is made to overcome his problems. . . . Such children are lost, and to their lost lives are associated a bitterness and anger far greater than in the lives lost by death. For these lives are thrown away.[16]

Yet, it must be remembered, always, that even with maximum help, not all children can be rehabilitated.

What Are They Like?

What does a mentally ill child look like? How does he act? What does he say? These questions, too, are likely to occur to anyone interested in the problem.

As one father put it, it is ironic that many of these children are nice looking. And appearing normal, they arouse normal expectations in others.

Although their actions differ widely—some children have large

[15] Lauretta Bender, "Twenty Years of Clinical Research on Schizophrenic Children, with Special Reference to Those Under Six Years of Age," *Ibid.*, p. 509.

[16] Helen Moak, *The Troubled Child* (New York: Henry Holt and Company, 1958 [now Holt, Rinehart and Winston, Inc.]), p. 103. Reprinted with permission.

vocabularies but cannot put a sentence together in sequence, others can perform difficult muscular tasks but cannot speak—their similarities are described succinctly in a book to parents:

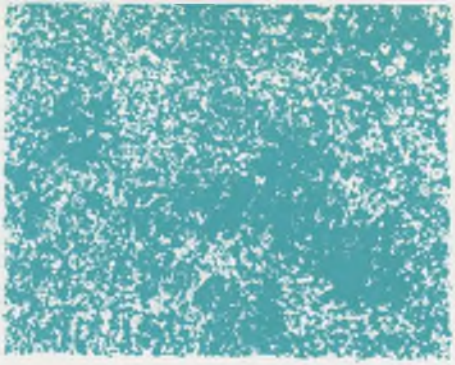
> These children have a serious deficiency in their ability to give and receive pleasure in social situations. They are, it would appear, not affected by the desire to be accepted socially and to receive the benefits of continuous, satisfying social relationships. They may be completely indifferent to human relationships, and not give any special recognition even to their parents, or may be cleverly insulting at every opportunity. In their rejection of, or indifference to, social contacts they may reject speech and hearing, or may develop a breathtaking verbal fluency.[17]

The disturbed children may disrupt the life of the home, interfere with activities of the brothers and sisters and the parents, destroy all that is in the way, and eat in such a crude manner that other people cannot eat with them. Many of these children are uncontrolled in their toilet habits and require constant supervision to keep healthy and clean. Other children sleep so little that parents must divide the watch at night in order to get any rest at all.

This is not a pretty picture. Looking at the child, one might wonder what hope there is for the youngster or why parents should invest their life's energies and life's savings in trying to rehabilitate these children. The answer lies, of course, in man's basic humanity toward man, in our human faith in the worth of each individual, in the social waste of any disabled person. These children must be helped because behind the hurt, the wall, the misbehavior, the anger, and the terror, they are children with needs, needs which must be understood.

We have looked at the seriously emotionally disturbed children through our own eyes, through the eyes of parents and teachers, of professional workers and lay people. But how do these children look to themselves? That is a disturbing question, which is often hard to answer.

[17] Getz and Rees, *Mentally Ill Child*, p. 7.



How Do They See Themselves?

How do these children see themselves? Strangely, some of them do not see themselves at all. These children may fear to look into a mirror because they do not know what they will see. In fact, some theories hold that these children are confused about their bodily identity. They lose contact with their extremities; they are insecure, unsafe, unable to determine what they are or where they are. Afraid to sleep, they fear that they might vanish in the night. They have no reality to which to hold. The parent, teacher, or therapist sometimes can teach and train the child to trust again, to feel again, and to see again.

It is frightening to live with no sense of identity, and these children often meet the problem in the only way that they know—by retreat. They turn from people, sometimes deny to themselves that they are human, and in so doing, find the only safety which is available.

Many of these children live with accepting parents. In the case of a great number of children there seems to be no apparent reason for their withdrawal or fear. Only these youngsters have somehow been deeply hurt and have pushed aside the world which has hurt them. They learn that "things" are real and can be counted on; they feel that human beings often are unreal or unreliable. Thus, some of these young children act like "things" themselves. Because they cannot trust others, they cannot, by the same token, trust themselves or believe in themselves as human beings. They "turn off" hearing or speech or motor development. What adult faced with a painful toothache or minor surgery has not wished for or asked for anesthesia to smother the pain with forgetfulness and fear with oblivion? These children use retreat as their anesthetic, denial of reality as their salvation.

Dr. Bruno Bettelheim describes these children in this way:

> . . . It is not that they have deviately organized personalities, but that their personalities are not sufficiently organized. In most cases, their living experiences have failed to coalesce and stayed fragmentary to such a degree that no more than the rudiments of personalities have developed.
> Some children show such a total lack of repression (e.g., control of aggression) that they are hardly socialized at all. Others have failed so completely in their defensive efforts that they have given up entirely trying to get along in this world; they have withdrawn from it totally, including an unwillingness to speak, or to eat. Hence our main task is to bring some intelligible order into chaos. The reorganization of disjointed personalities is secondary, and by comparison a much simpler task, but it comes only much later, if at all.[18]

The faces of many of these children are sorrowful, presenting a classic picture of desolation. These youngsters can often be observed in grief-bent postures, unresponsive to the living world around them. They have been driven into a sorrow from which they cannot emerge without professional help.

The effect of the illness on the children has been dramatically pictured by Thomas B. Congdon, Jr.:

> Whatever the cause, the hideous effect of the disease seems to be to disrupt the growth of certain mental images the child needs for normal living. To understand, imagine yourself walking down a busy street. Imagine that your own body—its boundaries, its dimensions, its exact location—suddenly becomes an unknown. In reality, you are still safe on the sidewalk, but your mind overwhelms you with the feeling that you are flying along or spinning, that the pavement is undulating and the curbstone an impossible cliff. The lamppost you hug for support seems to merge with your body. Without the vital concepts of gravity, time, space, and "self," everyday life becomes chaos. . . . This . . . may be the world of the young schizophrenic, with the intensity of these distortions varying for each child.[19]

[18] Bruno Bettelheim, *Love is Not Enough* (Glencoe, Illinois: The Free Press, 1950), p. 27.

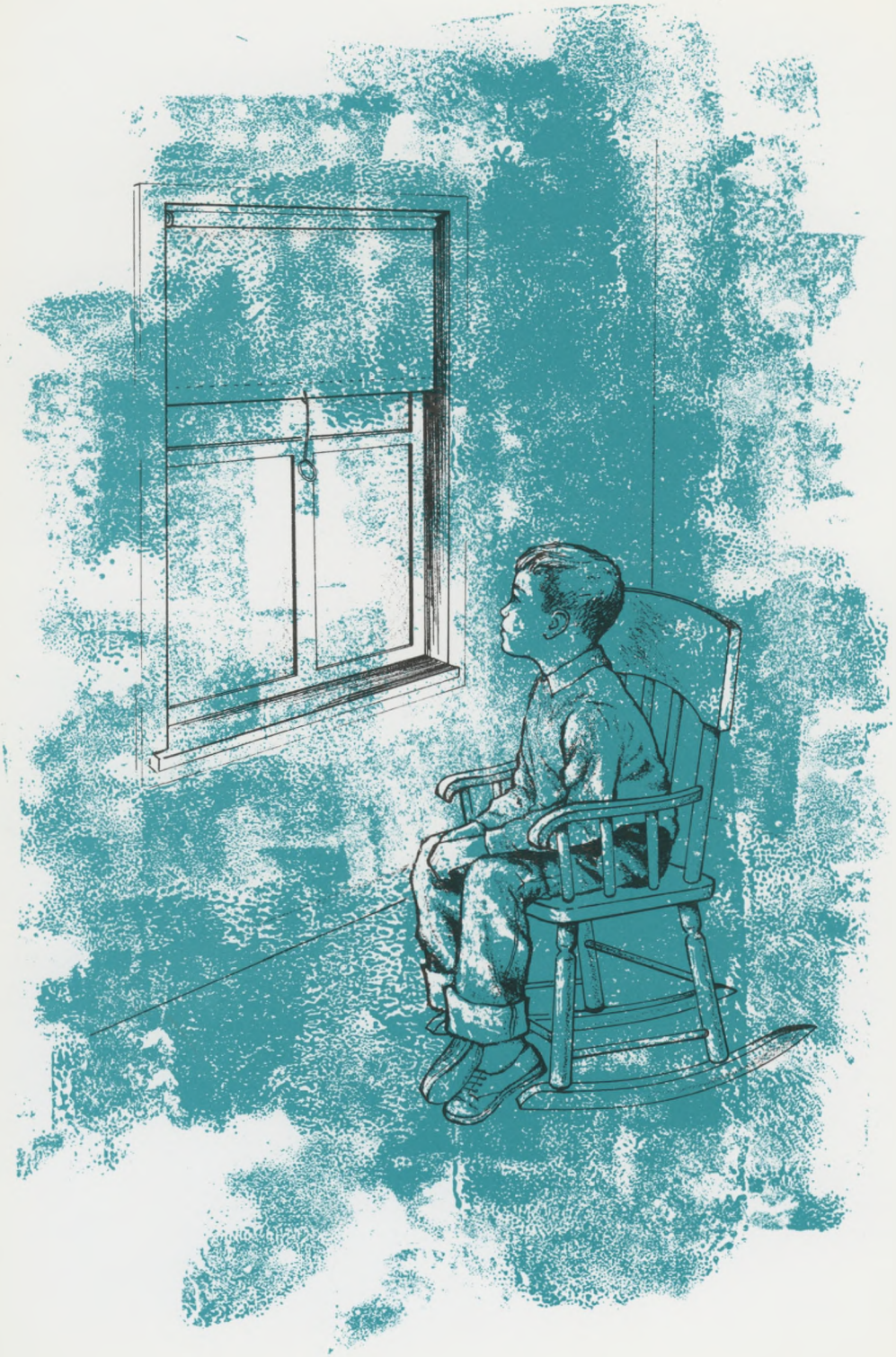
[19] Thomas B. Congdon, Jr., "The 'Attic Children' Go to School," *The Saturday Evening Post* (October 1, 1960), p. 56.

What Next?

Because their difficulties are multiple and the manifestations of them so varied, no one can set out a pattern which will fit for every mentally ill child. On the contrary, each child presents a unique challenge. Therapists and teachers have learned that they must find some way to get a glimmer of response. For some children, it may be through finger painting. For others, the sound of music. For still others, the brightness of keys jangling in the sunshine.

It is almost as if these children have fallen into a well, dark and deep. We can hardly see them, can barely reach them. Some of them may be in full view of us; others are slipping beneath our grasp. And we have to use every or any means to hold to these children and to bring them back to light and to life.

Many patterns and combinations of patterns have been applied to these disturbed children. In the next section we shall look at some of them, with special emphasis on what is being done. We shall trace the steps of some of these youngsters who have been led out of the twilight zone into the day of life again.



Work with emotionally disturbed children has ranged from keeping the child in the family and giving him special therapy to removing the child completely from his home and community and putting him in a different and new setting. Between these two extremes are many techniques, all of which have been attempted with varying degrees of success.

As we saw in the first section, the children differ; their home environments vary; and their responses deviate. Consequently, no one can point to any single pattern and cite it as the only or the best one.

Some of the chief difficulties in serving these children are set out as follows:

> Fully staffed residential treatment programs involving the traditional psychiatric team (psychiatrist, clinical psychologist, psychiatric social worker, psychiatric nurse, sundry kinds of therapists, teachers, aides) are expensive, as already indicated. Moreover, highly trained personnel required for such programs are now and will remain in short supply. These facts mean that we cannot meet requirements for residential care for all children needing it by building exclusively on the psychiatric team model. Such programs are essential but must be used selectively, with clear goals in mind and costs carefully considered.[1]

Awareness of the plight of the mentally ill child is relatively new, and the public is only now recognizing the needs of these young people. This group is small numerically but important to everyone because their special problems often cost communities either in tax money spent or later imprisonment or hospitalization or in the present costs for special services.

The Therapist

On the individual basis in which a psychotherapist usually works with a seriously disturbed child, the inner conflicts, the effects of emotional traumata which have occurred in his short span of life, the fears which hold him back—all of these may be resolved in the months and sometimes years of patient therapy which is required. Some examples can show the different ways the experts view children with various degrees of disturbances.

In her discussion of the qualifications of child analysts who plan to treat seriously disturbed children, Beata Rank comments:

> First of all the child analyst who undertakes the treatment must have the capacity for an unconditional acceptance of the child as he presents himself, making no demands which he is not ready to meet and trying only to understand the meaning of all his odd behavior.[2]

[1] *Crisis Child Mental Health*, p. 273.

[2] Beata Rank, "Adaptation of the Psychoanalytic Technique for the Treatment of Young Children with Atypical Development," *American Journal of Orthopsychiatry*, XIX, No. 1, 1949.

Whatever the degree of disturbance of the child, the therapist tries to see causes and solutions, to work with all his skill to help the young person find strength to face the realities of life. Dorothy Baruch, who writes of her experience with one little boy who typifies many, says:

> . . . He was a child so hungry for love that he wanted to slip back to the beginning of his life in order to make up for what he felt he had lacked. He wanted a second chance at being a baby so that he might gather into him the sense of being loved for himself, not for what he did or accomplished.[3]
>
> There is no child alive who is not at times angry at his parents. Too often we lose sight of the fact that honest loving comes side by side with honesty of feeling of every sort. Hate does not exclude love unless it is so tightly packed inside a person that it walls love up with fear and guilt.[4]

Again, Mira Rothenberg describes the relationship between Jonny and her on their first meeting:

> It was clear too that the relationship between us was to be a real one, an honest one, that I loved him enough, understood him well enough to know him beyond his defenses, into his shell; that I would protect him not only against the outside but against himself. . . . He recognized that I was stronger than he and that I intended to use my power for welfare and protection so he could become a child, helpless and weak, yet responsible.[5]

Clearly, then, each therapist works in his own way and yet toward the same goal—the growth of the child who is in his care. The therapist helps to supply a new, healthy personality with whom the child can identify and to offer the child the opportunity to correct old, false, inadequate misperceptions of his internal and external environment. Some of these children are "stuck" in an infantile pattern in an area of personality development. Some of them have to go back to babyhood to relive an experience, to work through the angers and the fears which the experience has given them, before they can move ahead from that point into the respon-

[3] Dorothy W. Baruch, *One Little Boy* (New York: Julian Press, Inc., 1952), p. 14.

[4] *Ibid.*, pp. 46–47.

[5] Rothenberg, "Rebirth Jonny," pp. 63, 64.

sible role of their own age group. If there were enough therapists to work with all of the emotionally disturbed children (some on a short-term basis, others over a long period) an enormous amount of human suffering would undoubtedly be relieved. The therapist can be a vital anchor to a confused child:

> It is a very special relationship, not quite like any other. It has a constant balance. On the one side is a child, with problems; on the other, an adult schooled in the various theories of how the mind works and how behavior develops. . . . Furthermore, the therapist is, or should be, a well-organized, mature person against whom an unorganized and confused child can begin to set his life in order.[6]

Yet for every Jonny or Kenneth who sits in the play therapy room and gropes his way out of emotional twilight, there is an army of Jonnys and Kenneths who stand in the dark hallway of mental illness, giving their unspoken cry for help.

But there is a serious shortage of child psychiatrists and trained personnel in related professional disciplines, and they are concentrated in certain parts of the country. What then can be done?

The Family

The fact that individual therapy is impossible for large numbers of children has led to the seeking of patterns or combinations which might work. It must be recognized at the outset that no matter what treatment combination is used, some mentally ill children do not improve. Most experts feel that while some home situations may contribute to the child's difficulties, many homes can provide the best setting for a child's rehabilitation. They believe that usually he can make a better or more permanent recovery if he can remain in the family setting while treatment is carried on. Even residential treatment patterns differ one from another. In some, the child is removed from the family and community and does not have contact with them for a matter of months, until patterns can be changed. In others, a therapist works with the child's family while the child is in the residential treatment facility, and in still others, frequent contact between child and parents is maintained

[6] Moak, *Troubled Child*, p. 97.

during the period of residential treatment. Once again, it cannot be said that any one pattern is infallible or that it is better than the others in all cases.

Certainly one can recognize how very difficult it would be for a family to give much help to a seriously disturbed child. Within the group rest all kinds of personal problems—the parents' reaction to the disturbed child as a reflection of themselves, the brothers' and sisters' anger and hostility at the youngster who disrupts a household and destroys their possessions, the family's own emotional needs which often have to be deferred while an all-out effort is made to aid the youngster.

Yet, despite the difficulties, the fact remains that the family is the unit of which the child is a part and that if the members can give the child a real sense of belonging, of being needed, of being loved for himself, they will make a great contribution toward his recovery. One mother who has lived through the experience of keeping a mentally ill child in her home expresses the idea thus:

> Any family determined to do so can capitalize on the healing forces of family relationships. . . . Creating surroundings in which a troubled child can best find recovery is enormously important, but it is only the beginning of the task. . . . There is no magic formula for the rest of it. Each family must base its method of handling the situation on what it intuitively knows is right for the child . . . we who have cared for troubled children can sum up certain underlying principles. The first of these is acceptance, the wholehearted acceptance of the child just as he is. . . . For parents, acceptance means many things. It means giving the troubled child the dignity of being treated as an individual who is important to the parents. . . .[7]

As the mother of four children, one of them mentally ill, Mrs. Moak has undertaken her obligation as a parent with seriousness and empathy. She says again:

> It is the parents' job to help the troubled child love himself. Only through the parents' total acceptance is he reassured that he is a person of worth, a being important to another. Self-respect is the first step he makes toward loving relationships with others; it is his mother and father who can teach it to him through every moment of the day.[8]

[7] *Ibid.*, p. 72.
[8] *Ibid.*, pp. 74–75.

School Aids

Many combinations of school programs have been attempted for the seriously disturbed child, depending, of course, on the extent of his disturbance and the program of the school. In many schools children have been permitted to stay in their regular classrooms as long as they could function there but have gone to special classes for part of the day, as they needed to do so. In other schools there has been set up a fixed schedule of part-time classes for the disturbed youngster.

These special classes are, of course, manned by people trained to work with troubled children and skilled in methods of handling youngsters with problems. In these classes the child does not have to sit still for hours, particularly if he is a hyperactive child to whom long periods of being still are near-impossible to endure.

Other schools try still another pattern, that of having special classes in specific subjects for the troubled children. For example, classes in speech or hearing therapy or special gymnastics might be instituted for young people whose problems manifest themselves in speech, hearing, or motor difficulties.

One of the factors which makes decisions about emotionally disturbed children difficult is that there has to be a constant weighing of the points for and against schooling in a regular school setting. In some instances the normal school procedure is excellent for the youngsters; in others, the child may be so disturbed that the time he takes from teachers and administrators in regular classes might make his care in school too expensive.

In this country attention has been more and more centered on the handicapped child, the youngster with orthopedic difficulties, the blind, deaf, and retarded. Yet the needs of the disturbed youngster are relatively new to many people and are only now being recognized in a systematic way. Some facilities are being tried for children who are less seriously disturbed than many described here. In New York, for example, psychiatric treatment is given for youngsters through guidance clinics which are operated by the

Board of Education. The Parent-Teacher Association in Los Angeles maintains a guidance clinic for children of school age. In Toronto, Canada, the public schools are providing programs for troubled children. "There is indication that, more and more, public schools will begin to offer special educational programs for children with difficult emotional problems."[9]

Naturally, all of the children who fit into these special programs in a normal classroom must be those who are not so disturbed that they cannot conform in a measure to the routine of a school. And while the greatly disturbed youngsters do need such special facilities as residential treatment centers, many of them can be helped through school programs or through combinations of schooling and residential treatment. In Brooklyn the League School is one model.

> In 1953 the League School for Seriously Disturbed Children challenged the ancient legend that the drastic surgery of separating a child from his family by hospitalization or placement in a residential center was the best and only solution for mentally ill children diagnosed as schizophrenic, autistic, or psychotic, and considered uneducable and untreatable. The League School offered a simple alternative: to take these children out of hiding and place them in a day-school program that would give them a chance to live and grow within their own family and community.
>
> The League School began with the hypothesis that positive behavioral changes could be achieved by the use of special educational techniques in a therapeutic setting without individual psychotherapy. This hypothesis was based on the assumption that a properly planned and highly individualized program of special education with interdisciplinary participation could result in social and emotional growth as well as educational achievements for many mentally sick children.[10]

Another unique program for emotionally disturbed children is called Project Re-ED. It started as an eight-year cooperative effort of the states of Tennessee and North Carolina and Peabody College, made possible by a long-term NIMH pilot project grant.

> At capacity each Re-ED school will serve 40 to 50 children, ages six to twelve (originally), in an around-the-clock reeducation effort

[9] *Ibid.*, p. 119.

[10] Carl Fenichel, "The League School for Seriously Disturbed Children," *Crisis Child Mental Health*, app. c, p. 307.

that, coupled with intensive work with the child's parents, regular school, and community, seeks to return the child as quickly as possible to his normal life setting. Each school has a creative, challenging educational program, supplemented by primitive camping. The children are normal to superior in intelligence, but they have all been in serious trouble in school or have been unable to attend school. Labels such as emotionally disturbed, behavior problem, antisocial, withdrawn, schizoid, and schizophrenic appear in the children's records. The children are usually referred by psychiatric clinics.

Re-ED schools are staffed by teacher-counselors and liaison teachers, carefully selected young people with a background in teaching or other work demonstrating a meaningful commitment to children. We refer to them as "natural workers" to imply that we try through careful selection to capitalize on individual differences in ability to work with children, a product of an entire life history not likely to be modified much by professional training. Teacher-counselors actually receive nine months of graduate education leading to the Master of Arts degree. On the job they are backed up by consultants from pediatrics, psychiatry, psychology, education, and other fields, this backstop by high-level talent being essential to the success of the Re-ED idea and an important strategy in extending scarce mental health manpower.[11]

Successful programs for working with disturbed children and with normal children simultaneously have been effected in normal elementary schools with several specialized programs including some for troubled children. The school authorities work on the premise that rejection and isolation are two emotions which the disturbed child has felt too deeply and that contact with normal children is beneficial. Within the schoolroom, special help is often given to the disturbed youngster, but he is not isolated or placed youngsters to preserve the delicate balance which permits the school to function as an institution of learning and yet help those who need assistance.

A program like the one mentioned above can well serve as a pattern for many other types of schools throughout the country. As public awareness of the needs of these youngsters grows, undoubtedly still other patterns will be begun.

[11] Nicholas Hobbs, "Project Re-ED," *Ibid.*, app. d, pp. 310–311.

A new idea growing in several of the Southern states results from awareness of the shortage of trained personnel and of the need for some kind of treatment center and schooling facilities. This concept is based upon one method found in Europe where finances are inadequate for more expensive approaches. Here facilities are staffed largely by *educateurs*, carefully trained and selected people with skills in working with children. Although they have frequent consultations with psychiatrists and other mental health specialists, they take most of the responsibility for working with ill youngsters in a residential setting. This theory is similar to that described previously.

This plan is based on a belief that there is a therapeutic potential in school activities and that the school has a central role in a child's life. Supporters of this idea feel that the isolation of the child from his school environment while he is undergoing treatment and the later return of the youngster to a class below him in age adds to his feeling of inadequacy and isolation. They also believe that many children who are too ill to function in a regular school setting are not sick enough to be hospitalized. For these children some special facility is needed. In other words, this kind of residential school is meant to help bridge the gap between the community clinic and the hospital.

In each residential school, there could be about 40 children, and classroom teachers, especially selected and trained, would be responsible for their care during the school day. After school hours, professionally-educated teacher-counselors would be responsible for the children until time for them to return to school the next day. The professional team of psychiatrists, psychologists, social workers, and others would work with the classroom teachers and the children.

Others believe that the daytime experience alone in such a school can be helpful and even less costly. In one residential treatment center youngsters are brought from their homes to the center in buses to go to school during the daytime. The teacher here is a regular school teacher with special training, but behind her is a whole battery of psychiatrists, psychologists, social workers, and others to assist with serious problems. Children's abilities may

range widely in various areas of this work. Much remedial teaching is done on a one-to-one basis.[12]

Teachers working with disturbed children need special skills and special training. The problem of teacher recruitment is a serious one. In describing a psychiatric day treatment center and school in New York City, the authors of an article say:

> Few programs embrace teachers in a team as does this one. Considerable difficulty in recruiting suitable teachers had increased our awareness of the lack of organized specialized training for teachers of disturbed children. . . . Our teachers have the satisfaction of working closely with clinical disciplines in which there is a mutual interchange allowing better understanding and growth.[13]

That the teachers working with these disturbed youngsters become the learners is demonstrated in these words spoken by Karl Menninger at the dedication of the children's hospital:

> I remember some prophetic words uttered by my teacher, Ernest Southard, many years ago. "We are going to learn about education," he said, "from studying the child who can not learn, not the ones who can. Psychiatrists will learn from children."[14]

Organized National Effort

A small group of parents bound by a common bond—their children's hospitalization in the observation ward of Bellevue Hospital in New York—formed the nucleus in 1951 for an organization called the League for Emotionally Disturbed Children, Incorporated. The hospital staff permitted these parents of schizophrenic children to meet together, and, once they faced each other, the weight of guilt, shame, and helplessness lightened. The local group became a national one four years later, and in 1959 the body was

[12] From a report on Hawthorn Center by William C. Morse at a meeting of the American Orthopsychiatric Association, 1960.

[13] Ruth L. LaVietes, Wilfred C. Hulse, Abram Blau, "A Psychiatric Day Treatment Center and School for Young Children and Their Parents," *American Journal of Orthopsychiatry*, XXX, No. 3 (July, 1960), p. 475.

[14] Karl Menninger, "Dedication of the Children's Hospital, Topeka, Kansas," *Bulletin of the Menninger Clinic*, XXV, No. 1 (January, 1961), p. 7.

named the National Organization for Mentally Ill Children, Incorporated.

The League worked with other interested organizations to encourage states to assume the responsibility for the education of mentally ill children, as they do for other handicapped youngsters. Success has come in New Jersey and New York where local Boards of education have been asked to set up special services within the public school structure.

This is the policy of the organization:

> We support the principle that mentally ill children should be kept and maintained in the community when this is indicated on valid diagnostic grounds.
>
> We encourage and endorse community planning proposals that call for small community-based "Child Care Centers" integrating outpatient day care, foster home, and residential treatment services. When separation of the child from the family is deemed necessary, appropriate residential treatment units for children, under state hospital and voluntary auspices, should be easily accessible to urban areas to promote family contact and therapeutic involvement.
>
> We subscribe to the thinking that the etiology of mental illness in childhood is multi-determined, representing a combination of biological and environmental elements.
>
> We encourage research investigations into the diagnosis and etiology of mental illness in childhood.
>
> We endorse and support the principle of integrated treatment-research operations.[15]

Other Patterns

Many combinations of care have been attempted throughout the country; some depend on the facilities available in the area, and others are based on the needs of particular groups of children. The boys' ranches which exist in almost every state, for example, are planned mainly for the aggressive and acting-out youngsters. There an environment is created which is both supportive and limiting

[15] *The Mentally Ill Child in America* (New York: The National Organization for Mentally Ill Children), pp. 27–28.

and which is geared to boys who have had inconsistent, cold treatment throughout their lifetimes.

All families with emotionally disturbed children can find help through community guidance centers wherever such centers exist. However, directors of the centers are the first to point out that a critical need exists for some type of residential treatment for those children who are too sick to remain in the home setting and to continue in regular school. Child guidance centers perform a greatly needed service for troubled youngsters and their parents. Such guidance centers are generally supported by united funds or community agencies and are able to let parents pay only what they can afford.

The child guidance centers, which generally handle all but the severely psychotic or acting-out child, were established in this country as early as 1909. They came into prominence after World War I, utilizing the team approach of psychiatrist, psychologist, and social worker to attempt together to prevent juvenile delinquency. This goal spread to an effort to help children with emotional problems, with professional training as an integral part of the movement.

The child guidance centers are increasingly working with schools, parents, and community organizations to help provide a milieu in which the child can develop his own strengths. The guidance clinics have been a prime source for treating disturbed children and their parents, for training child psychologists, clinical child psychologists, and psychiatric social workers. Their staffs have done a great deal of consultation with schools, physicians, and nurses. The worth of the child guidance center has been proved a thousandfold, but the need still remains for a second line of defense for those youngsters who are seriously mentally ill and who need more help than that which can be obtained in the guidance clinic setting.

Still another program which has been tried with good success is the Salesmanship Club of Dallas, Texas. Here a camp setting is used to provide a 12-month program for youngsters who have been seriously delinquent or emotionally disturbed in other acting-out or aggressive, harmful ways. For more than 20 years the camp-

ing project has been supported by a group of interested members of that civic club.

In this program the boys build their own year-round shelters, cooking and sanitary facilities. The theory behind this camping program is that in this uncomplicated setting, a disturbed boy faces basic realities. Here he is able to acquire self-sufficiency and to learn how to get along with other people in order to function better in the larger society to which we will return. The campers are provided with psychiatric treatment by several private psychiatrists or through the child guidance clinic, and some of these youngsters, as they prove their readiness for school situations, are able to attend regular public schools. A case worker keeps meeting with the family and also helps to plan the follow-up program. Members of the civic club maintain contact with the youngsters after they leave camp.[16]

Perhaps the most ambitious study was conducted in 1965 by Dr. Eli M. Bower of the National Institute of Mental Health and by Dr. Nicholas Hobbs of George Peabody College for Teachers. They based their work on meetings with the evaluation committee of the Salesmanship Club and with concerned professional persons in Dallas. They spent time at the camp and studied previous reports done by Mr. Wilbur Clarence Breining, Jr., by Mr. Maurice Hunt of the Child Welfare League of America, and by the Youth Study.[17]

> Your greatest capital asset is not the camp property but is the collection of concepts that have been hammered out over long years of experience maturely reflected upon.[18]

Several crucial problems face those who are concerned with providing expert care. "Recruitment" of professional people has too often been a "borrowing" technique from one state to the other. Now, it is felt, the answer to the problem lies in the training of professional workers right in the state, in psychiatric residence pro-

[16] See Bert Kruger Smith, *The Worth of a Boy* (Austin, Texas: The Hogg Foundation for Mental Health), 1958. Revised 1970.

[17] Smith, *Worth of a Boy*, p. 25.

[18] *Ibid.*, p. 28.

grams of medical schools and hospitals, in child guidance clinics, and in residential treatment.

Another serious problem, according to the leaders in the field, lies in the area of research. If, as has been said, there may be organic causes of childhood schizophrenia, research may cut down on heartache, time, and expenditures of large sums of money. If organic causes are not involved completely, other treatment procedures need to be developed and tested. Research is needed greatly in all areas—in genetics, biochemistry, and child-rearing practices.

Thus, residential treatment centers, valuable in the treatment of emotionally disturbed children, become vital in the area of training and research.

Residential Treatment Centers

All the patterns of work with the emotionally disturbed which have been described—day care centers, school aids, guidance clinics, private psychotherapy—still leave a small core of very sick children needing care away from home. For them, residential treatment is necessary.

> In 1968 a survey revealed that 97 percent of the children in residential treatment were in private institutions. In 1966 there were a little more than 8,000 children in residential treatment centers; the number of seriously ill children under eighteen during that same year was estimated at 1,400,000. There were 276 residential treatment institutions for emotionally disturbed children in this country in 1966. A number of states and territories had no such institutions.[19]

What, exactly, is the residential treatment center? We have seen that it should be used for only the tiny percentage of children who cannot benefit from care while living at home, in a foster home, or in a nonmedical situation. Just as people with severe physical disorders require hospitalization for 24-hour-a-day professional care, some children are so severely disturbed that they require "round-the-clock" treatment in a specialized facility.

[19] *Crisis Child Mental Health*, p. 272.

They need an all-embracing therapeutic environment and care which includes attention to their total development. For instance, they need individualized, highly skilled attention to their educational and recreational requirements. Their daily routine needs to be handled with psychological skill. These children need the help of highly trained mental health specialists who also serve as directors and consultants to a team of other professionals and nonprofessionals involved in delivering the wide range of services essential for their full care. Trained personnel should be readily available to conduct life-space interviews—that is, discussions with children of their difficulties at the moment they occur or at the moment the child feels ready to talk about them. In most cases, counseling services should also be made available to their parents.

When the child returns to his own home—often after a prolonged period of treatment—he should be followed up with therapeutic services which extend to other important people in his environment, such as his parents and his teachers.[20]

It is the "evening children" who go to the residential treatment centers. They are the ones whose retreat has been so far or whose aggressions are so intense that they cannot be reached through the channels of home or school or outpatient clinics. These are the children whose hold on the sides of the dark well is weak. For them only treatment in residence can provide the total climate for help. As Dr. Bettelheim explains:

But in our treatment efforts which try to embrace the child's total life, we have opportunities for insight into the workings of personality development that fall somewhere between what the artist and the analyst can offer us. Because we live with the children twenty-four hours a day, we do not have to rely on symbolic substitutes for events that took place in the past to be able to understand what may have happened at that time. We can observe directly how those past experiences influence present behavior. But much more important is the fact that we observe and even participate in all activities which currently form the child's life. We see (and are often part of) the experience that brings about significant reactions.[21]

Beneath the names, the labels, the diagnoses these are frightened children. They are children without youth and human beings without balance of love and warmth which gives meaning to life at every age.

[20] *Crisis Child Mental Health*, p. 271.
[21] Bettelheim, *Love Is Not Enough*, p. 67.

THE PROBLEM of the mentally ill child is not simply the responsibility of his parents any more than is the problem of the crippled or of the retarded child. As Bert J. Miller says:

> Does prime contact with a problem mean prime responsibility for its solution? We think not. We believe it is the responsibility of the entire community. Our children, no more and no less than any other children, are tomorrow's community. We want to share our responsibility. We want to save our children. We believe that we can—if we get to them early enough with the proper techniques.[1]

The reason why community aid and state concern is necessary with the mentally ill child is simply that the problem is bigger than any one family or even any one community can handle. Preventive measures should be threaded through every town, and citizens should be solicitous about what services are available in their community. The establishment of such expensive facilities as residential treatment centers has to be the concerted work of many people in many places.

[1] Bert J. Miller, "A Parent's View," *Child with Brain Damage*, p. 10.

As has been pointed out, community caring shows itself in a number of ways:

> The community truly concerned about troubled children will be on guard for their special needs in every agency that touches the lives of children. That concern will make itself felt in juvenile courts, juvenile detention homes, and probation systems; in children's shelters and child-care centers; in adoption agencies and foster-home programs. It will manifest itself in measures designed to protect children caught in adversity, children who are victims of cruelty or neglect, children who have lost one or both their parents. It will be reflected in churches, in the programs of various organizations or groups who devote themselves to either fund-raising or preventive work allied with their field, or who devote themselves to the hard work of public education.[2]

United efforts are needed to provide a total program which can help our troubled children. The assistant director of the William Healy School of Chiacgo, a public residential treatment center for children, explained that the need of community concern for the establishment of a center exists for many reasons, including the expense of building and maintaining such a center and the community understanding needed to help these children in their trips out of the center and into schools, churches, stores, libraries, and communty programs.

Residential treatment centers have always been built because of the deep solicitude of a community or a state for its disturbed children. For example, in Illinois a two-year survey was undertaken to find out how many mentally ill or severely disturbed children existed. The mental hospitals were examined, and it was discovered that although they were built primarily for adults, 375 children between the ages of six and 19 were housed there. The idea of the William Healy School came about eight years before it was opened through the aid of the Institute for Juvenile Research, which kept seeing youngsters they could not help on an out-patient basis. The Institute approached the State Department of Public Welfare and the Council of Social Agencies, and the Illinois Society for Mental Health helped in making surveys and in

[2] Moak, *Troubled Child*, p. 156.

informing people of the need for the center. Thus the center came into existence!

> The costs of residential treatment centers are generally estimated at between $10,000 and $18,000 a year. However, effective residential treatment at an early age may well save later costs—costs which extend beyond economic ones and which are cumulative in terms of the burdens that untreated, ill children are likely to impose upon themselves, their families, and their society.[3]

The vital role of the community was spelled out in *Crisis in Child Mental Health* as follows:

> When a community plans for psychiatric services for its children, it must be concerned with the quantity and quality of the health, educational, recreational, and welfare services which it provides for all its citizens. Services for emotionally ill children and their parents cannot be set up in a vacuum. They are related to, and affected by, other programs and services: both those concerned with children and those concerned with adults. All community services overlap and complement each other. They should be thought of as parts of a whole, not separate and unrelated programs.
>
> Planning for comprehensive mental health programs should be coordinated with planning now going on in such areas as urban renewal and public housing, juvenile delinquency, the poverty program, and mental retardation. Great emphasis should be placed on the fact that mental health services for children are one segment of the total services in a comprehensive mental health program and that many and diverse facilities are component parts of this segment.[4]

It can be seen, then, that every aware citizen in every community shares responsibility for the severely disturbed and mentally ill child. A complex combination of services is needed, and each community, no matter what its size, can help provide the climate which makes for healthy growth in children and the services which aid the child in difficulty.

The National Organization for Mentally Ill Children, Incorporated made an evaluative report on childhood mental illness and the role of the organization to the White House Conference on Children and Youth held in 1960. They reported:

[3] *Crisis Child Mental Health*, p. 271.
[4] *Ibid.*, p. 281.

> We regard the unity of out-patient, day care, foster home, and residential treatment services as a significant concept in community planning for children. Where a range of related services now exists under single agency auspices, it is our hope that experience will document the validity of integrated community-based programs.[5]

Among the direct services which the National Organization for Mentally Ill Children suggests for the unified planning for emotionally disturbed children are: the development and extension of community-based out-patient day care and residential treatment facilities for mentally ill children; publicly subsidized "half-way houses" for children not yet ready for or discharged from residential treatment centers under state hospitals or voluntary auspices; sheltered workshops, vocational guidance and placement services for the mentally ill adolescent and young adult; the assumption of responsibility by all 50 states in the Union for the public education for mentally ill children who can be maintained in the community; a local program to give parents daily relief from the burden of home care for mentally ill children in communities which have not yet developed adequate day treatment facilities; and early case finding and prevention of mental illness in children through a program of education and collaboration with general medicine, pediatrics and people working in the field of early childhood education.[6]

[5] *Mentally Ill Child in America*, p. 21.
[6] *Ibid.*, pp. 21–22.

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